



FLEXIBLE SPENDING CLAIM FORM

Employee Name _____ **Member ID** _____
Place of Employment _____ **Group Number** _____

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

To submit a Health Care Spending Account you must:

1. Complete this form.
2. Attach copy of bill or receipt from the provider of service for all eligible expenses. Each EOB, bill or receipt must contain the following information:
 _Name of person receiving service _Amount charged
 _Date of service _Name of provider rendering service
 _Type of service
3. Attach the Explanation of Benefits from ALL insurance carriers for expenses that are covered under any group medical, dental, vision, prescription or hearing plan.
4. Retain a copy for your records.

MEDICAL EXPENSES

Amount of Claim	Patient's Name	Relationship to Employee	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I certify that either I and/or my eligible dependent(s) have incurred these expenses and have not been previously reimbursed and are not eligible for reimbursement under any other plan. Furthermore, I declare that I will not deduct these expenses on my own or anyone else's individual Federal Income Tax Return.

Employee's Signature _____ Date _____

**SUBMIT ALL CLAIMS TO:
AULTCARE FLEXIBLE SPENDING ACCOUNT
PO BOX 6910 CANTON OH 44706
Fax 330-363-2096**